

**Niwasa Head Start Preschool
Administration of Prescription Medications**

Medical Authorization

Date _____

I authorize that _____ be administered to
(Name Of Medication)

_____ by _____
(Name of Child) (Name of Preschool)

With the following instructions:

Start Date: _____ End Date: _____

Dosage: _____

Time of Administration: _____

Storage: _____

(Medication Received)

(Parent's Signature)

Administrative Record

Date	Time Given	Amount Given	Staff Signature	Comments	Parent's Initials

